ILLINOIS DEPARTMENT OF Healthcare and Family Services

Draft 4/13/10

Medically Fragile & Technology Dependent Children's Waiver	FACE SHEET

GENERAL INFORMATION

1. Child's Name:		**DSCC ID:**
2. HFS Computer ID:	**RIN:**	**HFS Case ID:**
3 Care Coordinator:	**Regional Office:**	
4. Date Submitted *(MM/DD/YY) :*		

Information About the Child

5. Date of Birth:	**Age:**	**Gender:** ☐ Male ☐ Female

6. Is Child Covered under Private Insurance: ☐ Yes ☐ No

7. Child's Address

Street Address:

City: State: Zip Code:

Telephone (Home): Telephone (Work):

Telephone (Cell): E-mail (if applicable):

Primary language for communication:

Information About Parent(s)/Guardian(s)

8. Parent(s)/Guardian(s) Name:

Street Address: ☐ (Same as child)

City: State: Zip Code:

Telephone (Home): Telephone (Work):

Telephone (Cell): E-mail (if applicable):

Contact Preferences: ☐ E-mail ☐ Telephone ☐ Cell Phone ☐ Mail
Best time to contact:
Primary language for communication:

Parent(s)/Guardian(s) Name:

Street Address: ☐ (Same as child)

City: State: Zip Code:

Telephone (Home): Telephone (Work):

Telephone (Cell): E-mail (if applicable):

Contact Preferences: ☐ E-mail ☐ Telephone ☐ Cell Phone ☐ Mail
Best time to contact:
Primary language for communication:

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Reason for Request

9. Indicate the type of request:

- ☐ Request for Formal Decision (LOC criteria not met)
- ☐ Approval of Initial Waiver Application
- ☐ Approval of Six Month Renewal
- ☐ Approval of Annual Renewal
- ☐ Approval of Reassessment due to a Significant Change in Status (***Check below <u>all areas</u> in which changes have occurred since the last assessment and update the relevant sections of the assessment.)***

Areas of significant change:

- ☐ Medical Status
- ☐ Social/Change in Guardian/Family Composition/Move to a New Home/Foster Home
- ☐ Behavioral
- ☐ Other: _____

WAIVER INFORMATION

10. Waiver Effective Date: ***(MM/DD/YY)*** _____ **MPHC Effective Date:** ***(MM/DD/YY)*** _____

☐ Initial Waiver Application (***Skip to Question 17)***

11. Date Current MPHC Plan or 2352 ends: ***(MM/DD/YY)*** _____

Requested dates for new plan: ***(MM/DD/YY)*** From: _____ to _____

12. Number of Nursing Hours per Week Currently Approved: _____

Current nursing rates per hour: RN: $_____ LPN: $_____ CNA: $_____

13. Approved for 336 Hours per Year of Respite? ☐ Yes ☐ No ☐ N/A ***(Skip to Question 17)***

If No, how many hours of respite? _____

Respite begin date (MM/DD) _____

# of Respite hours billed during current respite year? _____

14. Discontinuation Date of the Waiver/MPHC: ***(MM/DD/YY)*** _____

Reason:

- ☐ Deceased
- ☐ Denied by HFS
- ☐ Overage
- ☐ Other Resources
- ☐ Out of State
- ☐ Placed (Hospital or SNF)
- ☐ Services Not Desired
- ☐ Treatment Goals Achieved
- ☐ Unsafe Environment